Danger Assessment

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Contact information: _____ Date of assessment: _____ dd / mm / yyyy

This two-part risk assessment evaluates the level of danger an abused woman has of being killed by her intimate partner. The Danger Assessment helps women and anyone else involved be aware of the risk factors that apply to their specific situation, along with the danger of homicide in cases of abuse. It is not a predictive measurement tool. Please answer the questions honestly and accurately to obtain the most representative results.

PART 1

Using the calendar, please mark the appropriate dates during the past year when you were abused by your partner or ex-partner. On the date, write how bad the accident was according to the following scale. If any of the descriptions for the higher number apply, please use the higher number. 1. Slapping, punching; no injuries and/or lasting pain. 2. Punching, kicking: bruises, cuts and/or continuing pain. 3. "Beating up"; severe burns, contusions, broken bones, miscarriage. 4. Threat to use weapon; internal injury, head injury, miscarriage, permanent injury. 5. Use of weapon; wounds from weapon.

PART 2

1. Has the physical violence increased in severity or frequency over the past year?

◯ Yes ◯ No

2. Does he own a gun?

◯ Yes ◯ No

3. Have you left him after living together during the past year?

◯ Yes ◯ No

☐ If you have never lived with him

4. Is he unemployed?

◯ Yes ◯ No

5. Has he ever used a weapon against you or threatened you with a lethal weapon?

◯ Yes ◯ No

☐ If YES, was the weapon a gun?

6. Does he threaten to kill you?

◯ Yes ◯ No

7. Has he avoided being arrested for domestic violence?

◯ Yes ◯ No

8. Do you have a child that is not his?

◯ Yes ◯ No

9. Has he ever forced you to have sex when you did not wish to do so?

◯ Yes ◯ No

10. Does he ever try to choke you?

◯ Yes ◯ No

11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs or mixtures.

◯ Yes ◯ No

12. Is he an alcoholic or problem drinker?

◯ Yes ◯ No

13. Does he control most or all of your daily activities?

◯ Yes ◯ No

☐ If he tries, but you do not let him

14. Is he violently and constantly jealous of you?

◯ Yes ◯ No

15. Have you ever been beaten by him while you were pregnant?

◯ Yes ◯ No

☐ If you have never been pregnant by him

16. Has he ever threatened or tried to commit suicide?

◯ Yes ◯ No

17. Does he threaten to harm your children?

◯ Yes ◯ No

18. Do you believe he is capable of killing you?

◯ Yes ◯ No

19. Does he follow or spy on you, leave threatening notes or messages on answering machines, destroy your property, or call you when you don't want him to?

◯ Yes ◯ No

20. Have you ever threatened or tried to commit suicide?

◯ Yes ◯ No

SCORING

Total number of "yes" responses from 1 through 20:

4 points for each "yes" to items 2 and 3:

3 points for a "yes" to item 4: _____

2 points for each "yes" to items 5, 6 and 7:

1 point for each "yes" to items 8 and 9:

Subtract 3 points if item 3a is checked:

Total score (sum of points): _____

Please select one category for the respondent

◯ Variable danger ◯ Increased danger ◯ Severe danger ◯ Extreme danger

Additional notes:

HEALTHCARE INFORMATION

Name: _____ License ID: _____

Signature:

Date of assessment: _____ dd / mm / yyyy